1. Buffer Zone: Recommend the creation of a reasonable buffer zone that limits healthcare organizations operating under a Certificate of Public Advantage (COPA) or an entity owned, managed or controlled by an entity operating under a COPA from locating specific medical service lines within ten miles of an existing hospital or healthcare provider.

2. Future CON Applications: Recommend that any entity operating under a COPA or an entity owned, managed, or controlled by an entity operating under a COPA must submit as part of its CON applications a separate, third party economic impact analysis on existing providers with the goal being to maintain healthy competition and local access to services in the region.

3. Extend Physician Cap: Recommend that a physician employment cap associated with hospitals operating under a COPA be extended to the entity's true service area.

a. The physician cap calculation will exclude retired physicians, physicians who are employed by the government or military, residents and fellows, academic teaching physicians and physicians who spend more than 50% of their time on administrative duties. Physicians included in the calculation will be those who work full-time, have a full, active and unrestricted medical license from the State of North Carolina, and directly provide professional medical or surgical services.
b. "Employment" will be expanded to include Professional Service Agreements and exclusive contracts in the calculation.
c. To determine physician employment, each county will be calculated as a unique market using the physician's county of residence and their specialty area of practice as listed with the NC Medical Board.

4. COPA Reports: Recommend that COPA compliance reports be made annually to DHSR and audited both for financial compliance by DHSR and for operational compliance with the law by the NC Attorney General's Office. Bi-annually an economic analysis will be conducted by an independent economist selected by the NC Attorney General's office. Annual and bi-annual reports will be open to the public for review and comment which will be taken into consideration by both DHSR and the AGO before issuing the results of their review.

5. COPA Transition: Recommend that the Program Evaluation Division study and identify the circumstances, if any, under which a COPA may be withdrawn. Removal of a COPA must only be considered if sufficient documentation is presented to demonstrate that adequate competition has entered the healthcare market. Since a COPA is a substitute for competition, only competition can replace a COPA. Any request to end the COPA must be accompanied by empirical evidence that new healthcare choices are present and that the market share enjoyed by the COPA entity is reduced to a fair and reasonable level. A request to withdraw a COPA should require a public filing, hearings, opportunity for public review and comment resulting in a written

decision by DHHS and the Attorney General's Office which allows for appeal rights.

a. Also recommend that the PED conduct a baseline audit of the current entity covered by COPA and include a review of both financial and operational compliance. Included in this audit will be an analysis of whether the entity covered by COPA has affected regional health care pricing by engaging in joint contracting across services and markets ; engaged in contracting arrangements with commercial payors for services at their primary service location with their expanded services in low margin markets. This audit will also include an analysis of whether incentives exist under the current COPA law that allow for the manipulation of the COPA margin gap formula to raise outpatient prices and expand outpatient services, thereby increasing its costs and expansion into low margin markets. The PED should include a review of historical contracting practices to determine if regulatory evasion has occurred.